

<b>Case Number:</b>	CM15-0104975		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	02/13/2015
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: North Carolina  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 56 year old male who sustained a work related injury February 13, 2015. He was a restrained driver and was rear ended after coming to a stop on the highway. In the emergency department, he complained of pain in his mid and lower back, right side. He denied neck pain but had pain in his right back when he turned his head and occasional numbness and tingling to his shoulders bilaterally, when he lies on his side and when he gets up. X-rays were ordered and he was prescribed medication and physical therapy and diagnosed with a thoracic and lumbar sacral strain. According to office visit notes, dated April 21, 2015, the injured worker presented for a follow-up visit with complaints of back, neck and left hand pain. A check list revealed he felt the same after 8 visits of physical therapy. Objective findings checked off DTR's (deep tendon reflexes) symmetric and sensory intact. The handwritten notes and checklist are difficult to decipher. Diagnoses are thoracic strain and lumbar sacral strain. At issue, is the request for a TENS (transcutaneous electrical stimulation) unit.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

**Decision rationale:** The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation) not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. In addition there must be a 30 day trial with objective measurements of improvement. These criteria have not been met and the request is not medically necessary.